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ORIGINAL DEPARTMENT.

LECTURE.

ATTITUDE OF THE FOREARM BEFORE AND AFTER INJURY.

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GENTLEMEN:—I am going to talk to you today about the *attitude* of the forearm before and after injury.

The agents of motion in the forearm are nerves, muscles, and bones.

1. The nerves are active agents, inducing the muscles to contract.

2. The muscles are active agents, contracting and moving the bones.

3. The bones are passive agents, acting as levers.

The normal motions and attitudes of the forearm depend on the form and the relations of the bones, and on the distribution and the actions of the muscles. The abnormal motions and attitudes of the forearm depend on some injury to the nerves, muscles, or bones.

The normal motions of the forearm are flexion and extension, and pronation and supination. Ordinarily the forearm can be flexed and extended through an arc of about 160°. Sometimes the forearm may be extended normally so that its axis will make an angle posteriorly with the axis of the humerus. And the forearm can be rotated through an arc of about 180°, sometimes more and sometimes less. Let us call this motion rotary ginglymus; and, for the sake of convenience, let us call the motion of the forearm from side to side, lateral ginglymus. My attention was first directed to the lateral ginglymus of the forearm while comparatively examining an infant's forearms, one of which had been injured near the elbow joint: both forearms, in this case, had lateral ginglymus. Soon after, I made some measurements of the arc described by the lateral ginglymus of the normal forearms of infants and children. The average of the motions of both forearms is recorded in each instance. Let me submit to you the following table, containing the measurements of 15 cases. The forearm was fully extended on the arm, and the angle measured by a protractor:—

TABLE.

No.	SEX.	Age. Months.	ANGLE.
1.	Male.	3½	10 deg.
2.	Female.	1½	8 "
3.	Male.	3	20 "
4.	Male.	20	15 "
5.	Female.	60	12 "
6.	Female.	13	10 "
7.	Male.	54	12 "
8.	Male.	36	10 "
9.	Male.	54	4 "
10.	Male.	62	3 "
11.	Female.	19	15 "
12.	Female.	60	12 "
13.	Female.	3	10 "
14.	Male.	42	5 "
15.	Female.	12	10 "

The following conclusions may be drawn from this table, namely—

1. There are 8 males and 7 females.

2. The youngest is a female, one and one-half months of age.

3. The oldest is a male, sixty-two months of age.

4. The average age of the 15 cases is about thirty-three months.

5. The least arc of lateral ginglymus of the forearm, in the 15 cases, is three degrees.

6. The greatest arc of lateral ginglymus of the forearm, in the 15 cases, is twenty degrees.

7. The average arc of lateral ginglymus, in the 15 cases, is about ten degrees.

I have not yet been able to determine at what age the lateral ginglymus of the forearm ceases to be a practical fact. As the age advances the lateral ginglymus of the forearm diminishes, and is usually absent after puberty. I have not been able to find a case of normal lateral ginglymus of the forearm in the adult. At present I only allude to the possible relation of this motion to the epiphysal cartilages near the elbow joint. The lateral ginglymus of the forearm has an important bearing on the diagnosis of injuries of the elbow of the young. You already know how commonly the young have injuries about the elbow joint.

Let me show you some mechanical consideration that will aid you in understanding the functions of the forearm. Let *a* and *b*, in Fig. 1, be two rigid bars, attached to *H*, another rigid bar, in such a manner as to be moved like the bones of the forearm. Let *p m c* represent the pronator radii teres: *c* the origin, *m* the contractile substance, and *p* the insertion of the muscle. When a muscle contracts, it will bring, or tend to bring, the origin and insertion nearer together. Now let the pronator radii teres contract: the result is shown in Fig. 2, and may be expressed, in general terms, by saying that there are pronation and flexion of the forearm. And also, in general, it may be stated, that any muscle passing obliquely across the quadrangle of the forearm, from one angle to the other, or nearly in that direction, when contracting, will cause, or tend to cause, both pronation and flexion of the forearm. The force of pronation may be greater, or the force of flexion may be greater.

In the next place let me direct your attention to the distribution and function of the muscles acting on the forearm:—

1. The pronator quadratus is a simple pronator.

2. The pronator radii teres can pronate and flex the forearm.

3. The brachialis anticus flexes the forearm.

4. The biceps brachii flexes and pronates the forearm and supinates the radius. The pronating force acts through the semilunar fascia and the fascia enveloping the pronator radii teres and the carpo-radial flexor. The semi-

FIG. 1.

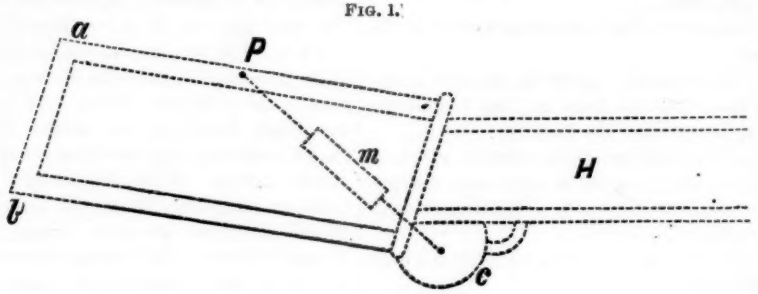
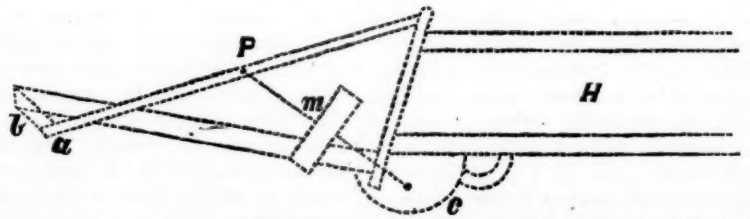


FIG. 2.



lunar fascia acts as a tendon: the biceps is, therefore, a bi-ped.

5. The flexor longus pollicis is a simple flexor.

6. The flexor carpi ulnaris is a simple flexor.

7. The flexor carpi radialis can flex and pronate the forearm.

8. The palmaris longus may tend to pronate the forearm.

9. The flexor sublimis digitorum acts, to a certain extent, as a pronator of the forearm:—

The pronator radii teres tends more to pronation than flexion. The carpo-radial flexor tends more to flexion than pronation.

10. The supinator longus acts as a flexor; it acts most as a supinator when the forearm is completely pronated; and it acts most as a flexor when the forearm is completely supinated.

11. The supinator brevis supinates, extends, and abducts the forearm: the abduction is found in cases where there is lateral ginglymus.

12. The extensor indicis acts as a supinator of the forearm.

13. The extensor internodii pollicis acts as a supinator of the forearm.

14. The extensor primi internodii pollicis is a simple extensor.

15. The extensor ossis metacarpi pollicis is also a simple extensor.

16. The long carpo-radial extensor extends the forearm, and supinates it when there is complete pronation.

17. The short carpo-radial extensor extends the forearm, and supinates it when there is complete pronation.

18. The carpo-ulnar extends and *pronates* the forearm.

19. The extensor digitorum communis and the extensor minimi digiti can act, to some extent, as *pronators* of the forearm.

20. The triceps brachii is a simple extensor, except in case it may act as a supinator through the supinator brevis, and as a pronator through the profundis digitorum.

In the next place, the following propositions can be proved:—

The muscles that directly and indirectly flex the forearm are more powerful than those which directly and indirectly extend the forearm.

I made transverse sections of the upper limb of a muscular male, whose cadaver had been preserved for dissection. First: I made a transverse section of the forearm three inches above the wrist joint: (1) The section of the muscles on the dorsal aspect showed an area of about one and one-eighth square inches; and (2), the section of the muscles on the palmar aspect showed an area of about two square inches. Second: I made a transverse section of the forearm four inches below the elbow joint: (1) The section of the muscles on the dorsal aspect showed an area of about two square inches; (2) the section of the muscles on the palmar aspect showed an area of about four and one-half square inches. Third: I made a transverse section of the middle of the arm: (1) The section of the muscles on the dorsal aspect showed an area of about two and one-half square inches; and (2), the section of the muscles on the palmar aspect showed an area of about three and one-half square inches.

From the above measurements may be drawn the following conclusions, namely—

I. In the lower part of the forearm the volume of the muscles on the posterior aspect is to the volume of the muscles on the palmar aspect as 9 : 16.

II. In the upper part of the forearm the volume of the muscles on the posterior aspect is to the volume of the muscles on the palmar aspect as 4 : 9.

III. In the middle of the arm, the volume of the muscles on the posterior aspect is to the volume of the muscles on the palmar aspect, as 5 : 7.

IV. In general, the volume of the muscles on the palmar aspect of the upper limb is nearly twice as great as the volume of the muscles on the posterior aspect of the same limb. The ratio may vary from the above estimate.

We will now consider some of the attachments of the muscles that move the forearm, and their mechanical relations. When the forearm is completely extended, the triceps acts on a longer lever-arm than the biceps and the brachialis anticus. When the forearm is semi-flexed, or completely flexed, the biceps and the brachialis anticus act on a longer lever-arm than the triceps. The average difference in the lengths of these lever-arms is nearly one inch in favor of the biceps and the brachialis anticus.

The extensors of the forearm, by means of their attachment to the external condyle of the humerus, act on a very short lever-arm. The flexors of the forearm, by means of their attachment to the internal condyle, act on a longer lever-arm than the extensors. The average difference in the lengths of these lever-arms is nearly an inch in favor of the flexors of the forearm.

A consideration of importance may be noted here, namely: It is well known that a muscle will increase in power and size by being used. And the increase in power is not all due to the increase in size. The muscles on the palmar aspect of the arm and forearm are used more than the muscles on the dorsal aspect of the arm and forearm, because the former are habitually made to overcome greater resisting forces than

the latter. Hence, intrinsically, the flexors are stronger than the extensors.

We may now record the following general conclusion, to wit. The flexors can overcome the extensors of the forearm, because they have a greater volume, because they act on longer lever-arms, and because they are intrinsically stronger.

In the next place, it may be stated, that some of the extensors act as pronators, that some of the flexors also act as pronators, and that none of the flexors except the biceps act as supinators of the forearm. Hence, the pronating force of the flexors and extensors of the forearm is greater than their supinating force. But the pronators proper are more powerful than the supinators proper. Hence, the entire pronating power is greater than the entire supinating power of the forearm.

In view of these dynamic facts, it will be seen, that the habitual attitude of the forearm, when it is at rest, will be described by more or less flexion, and by more or less pronation, because such attitude puts the contractile forces of the opposing muscles in equilibrium. And when there is a general and similar contraction of all the muscles acting on the forearm, there will be an attitude of flexion and pronation. Now, normally or abnormally, the attitude of the forearm will express the resultant of all the acting muscular components.

Some of my practical observations on the attitude of the forearm caused by injury, are noted under the following heads, namely:—

I. In the cases of supra-condyloid fracture of the humerus that have occurred in my practice, the forearm has been more or less pronated and flexed.

II. In the cases of fracture of the internal condyle of the humerus coming under my observation, most of which I have treated, the forearm has been pronated and flexed. Also the forearm was bent in laterally on the arm, obliterating the external angle normally made by the arm and the forearm: there was a lateral ginglymus at the elbow joint.

III. In the cases of fracture of the external condyle of the humerus that have been under my care, I have noted pronation and some flexion of the forearm. And there has been a less than normal external lateral angle made by the arm and the forearm. Also, there has been lateral ginglymus at the elbow joint.

IV. I have reduced several backward dislocations of the forearm. In every case there was pronation; but the tendency to flexion was considerably counteracted on account of the triceps operating on a lever-arm longer than the normal.

V. In a case of incomplete external lateral dislocation of the forearm, caused by direct violence to the inner side of the forearm, there was pronation and flexion of the forearm.

VI. In all cases of sprain and contusion of the elbow that I have treated, there has been more or less pronation and flexion of the forearm.

VII. All the cases of contusion of the forearm that I have ever seen have presented an attitude of pronation and flexion.

VIII. According to my observations, sprains and contusions of the wrist are apt to put the forearm in an attitude of pronation and flexion.

IX. The attitude of the forearm when the radius is broken may be expressed as follows:—

First. Suppose the radius is broken at some point between the base and the insertion of the pronator radii teres: In general, the forearm will be pronated and somewhat flexed. In particular, the base of the lower fragment will usually be turned outward and backward, the hand falling inward and forward. The radial side of the forearm will ordinarily be shortened. The upper fragment will be pronated and flexed, and drawn toward the ulna, especially when the fracture is in the attachment of the pronator quadratus. You will recall the anatomical reasons for the attitudes of these fragments.

Second. Suppose the radius is broken at some point between the insertion of the pronator radii teres, and the insertion of the biceps brachii: In general, the forearm will be pronated and flexed. In particular, the radial side of the forearm will be shortened, the upper end of the distal fragment will be carried forward and inward, and the proximal fragment will be flexed and supinated by the biceps.

Third. Suppose the neck of the radius is broken: In general, the forearm will be pronated and somewhat flexed. In particular, the upper end of the distal fragment will be drawn inward and forward. The radial side of the forearm will be shortened. The proximal fragment may be tilted forward with the upper end of the distal fragment. I need not tell you that all these attitudes will be changed by manual flexion, extension, pronation, and supination of the injured forearm. You will remember that the so-called lateral ginglymus of

the forearm of the young will also modify the attitude of the forearm whose radius is broken.

x. The attitude of the forearm when the ulna is broken may be expressed as follows: (1) When the olecranon is broken the forearm is pronated and flexed; (2) When the shaft of the ulna is broken, the forearm will generally be pronated and flexed. The ends of the fragments may be driven inward, outward, forward or backward, just as it may happen; and usually such is the application of the muscular force, and such is the interlocking of the broken ends of the fragments, that the fragments remain where they have been driven by the injuring force.

xi. The attitude of the forearm when both bones are broken may be expressed as follows: In general, the forearm is in a state of pronation and flexion. The broken ends of the fragments may project inward, outward, forward, or backward; and at the same time the radial may be found nearer the ulnar fragments, obliterating more or less of the interosseous space. I have oftener seen the broken ends of the fragments projecting somewhat inward and backward.

In general, the forearm, after it has been injured, is about semi-flexed, say nearly 80° from complete extension: to this statement there may be exceptions. And in general, the forearm, after it has been injured, is more than semi-pronated, say nearly 135° from complete supination: to this statement there may be exceptions.

Let me remind you of the following facts, namely:—

a. Flexion takes place all the way from complete extension to complete flexion.

b. Extension takes place all the way from complete flexion to complete extension.

c. Pronation takes place all the way from complete supination to complete pronation.

d. Supination takes place all the way from complete pronation to complete supination.

e. There is no lateral ginglymus in the adult elbow joint.

f. The lateral ginglymus in the elbow joint of the young will modify the attitude of the forearm, both before and after injury.

g. The principles I have explained to you in regard to the attitude of the forearm are the basis of a rational diagnosis and a sound treatment of most of the injuries of the forearm.

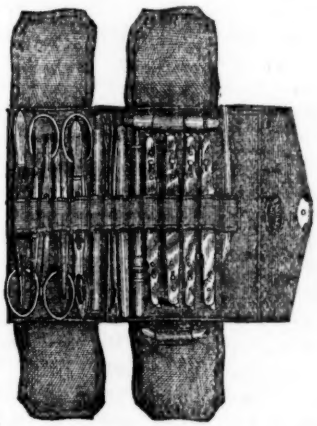
h. The better you understand the complex mechanism of the forearm, the better can you repair it when it is damaged.

Communications.

A NEWLY ARRANGED POCKET CASE, OF VERY SMALL SIZE, YET CONTAINING A THERMOMETER AND A HYPODERMIC SYRINGE.

BY W. W. KEEN, M.D.,
Surgeon to St. Mary's Hospital, etc., Philadelphia.

The pocket case here described and figured is smaller than most similar cases, measuring only 4½x2¼x1⅛ inches, yet it contains not only all the ordinary instruments, but also a thermometer and a hypodermic syringe. This is accomplished by the following re arrangement.



1. The *exploring needle*, instead of being a separate instrument requiring a separate space, is screwed into the straight joint of the *catheter*.

2. The *porte-caustique*, which also serves as the handle for the catheter, is shortened to two inches, so as to lie *across* the case at the end of the knives, which are 3½ inches long, and this saves another space for an additional instrument.

3. The *terminal joint* of the *female catheter* also is placed *across* the case at the other end of the knives. If, however, it were held by a leather sewed to the case, the knives could not be removed. Accordingly the leather is sewed to the flap, so that when opened it is out of the way, and the knives can be readily removed. It could, however, be placed between the knives and the porte-caustique, but this arrangement is not so convenient, I find, mechanically.

The above arrangement gives room, it will be seen, for three additional instruments, and I have added the following instruments, which

usually occupy separate cases, and much space in the pocket.

1. A *Thermometer*, the case of which is exactly four inches long and one-quarter of an inch wide (precisely the diameter of a number nineteen catheter, French scale). Usually the thermometers in the market are a little larger than this in both dimensions, but those of this size can always be procured by express stipulation.

2. A *Hypodermic Syringe.* This syringe, of Mr. Kolbé's device, is of metal, and of exactly the same diameter as the thermometer, but one-quarter of an inch shorter. The piston-rod is hollow, and receives the needle in its interior. The syringe holds twenty minims. I always carry some one-quarter-grain powders in the pocket, and twenty minims of water, gently warmed in a teaspoon by a match, will readily dissolve two grains of morphia without re-precipitation on cooling. Beyond this amount I have not tried, as not practically important. This method of administering morphia I always use, since the small amount of menstruum does less violence to the tissues, and the warmth of the water not only makes it more agreeable, but also increases the rapidity of its absorption.

3. Any other instrument can be added to the case in the third space gained. In my own, I have added a fourth double-bladed handle, with a knife in one end, and in the other a hollow, slightly curved needle. The needle (two inches long) is tubular from the point to very near the shank, and can be used for two purposes, (*a*) for passing a wire suture, or (*b*) for inserting a hare-lip pin. In this latter case, the needle is first passed, then the point of the pin is inserted in the tube of the needle, and the needle then is withdrawn, carrying with it the point of the pin.

In order to diminish the *thickness* of the case the handles of the scissors and the dressing forceps have a piece "exsected" from each handle, so that there are no two instruments one over the other. I do not find that this interferes with their usefulness. The curved branch of the male catheter has its beak in the pocket, and so the inconvenience of its overlapping the other instruments, and cutting off one corner, is avoided.

As now arranged, the case contains the following instruments from left to right:—

1. Pair of dissecting forceps.
2. Gross' instrument for removing foreign bodies from the ear.
3. Dressing forceps (with a catch).
4. Scissors.
5. Fenestrated bull-dog forceps.
6. Straight branch of catheter, with the exploring needle in it.
7. Grooved director and probes.
8. Thermometer.
9. Hypodermic syringe.
10. Double bistoury, straight.
11. Double bistoury, curved, one probe pointed.
12. Tenotomy knife and tenaculum.
13. Gum lancet and hollow needle.
14. Curved branch of male catheter, its beak in the pocket.
15. At the upper end, the porte-caustique and catheter handle.
16. At the lower end, on the flap, the point of the female catheter.
17. A pocket for needles, thread, etc.

Mr. Kolbé, of this city, has taken much pains to complete this case, and can furnish one at any time.

P. S.—While reading the proof sheet, my attention has been called to the somewhat similar pocket case of Dr. Gay (*Buffalo Medical Journal*, April, 1878), which I had not seen before. The case I have arranged, however, combines all the advantages of both Gay's and Gross' cases, with improvements upon each, and at nearly the same price.

CHLORAL IN THE TREATMENT OF TRAUMATIC TETANUS.

BY JOHN B. ROBERTS, M.D.

Read before the Philadelphia County Medical Society, June 26th, 1878.

In another place* I have reported several cases where hydrate of chloral seeemed to exert a curative power when employed in the treatment of tetanus resulting from surgical causes. It is my object, in this paper, to call the attention of the society to this drug in connection with tetanus, that its more frequent use may give light upon the subject, and enable us to determine whether it really does cure tetanus as quinine does ague. The treatment is, of course, not a new one, for almost every potent agent has been administered in tetanus, but I am inclined to believe that most surgeons have

* *American Journal of Medical Sciences*, October, 1877.

so little faith in remedies for this disease, that they do not give chloral a fair trial, but use it merely as an auxiliary to other drugs.

It should be employed in full and frequent doses, so that the patient may be kept, as far as is possible, free from pain and spasm, and may be allowed to obtain refreshing quiet and sleep, by having his sensibility to outside impressions and to pain blunted by the action of the drug. An average amount would be from one to two hundred grains daily, distributed throughout the twenty-four hours, according to the indications in each case. In most cases ten or fifteen grains of hydrate of chloral every two hours would probably be a sufficient dose, but I should not hesitate to exceed this amount if I found the patient still suffering pain, exhibiting clonic spasms, and unable to sleep. During the night the doses may be given at longer intervals, if the patient is comfortable. In one of the cases observed, who was treated by this method for tetanus occurring after laceration of a finger, one hundred and eighty grains were given during each twenty-four hours for four days, making, as is readily calculated, 720 grains during that time. When it is recollected that he had been taking smaller doses for two days previously, and continued to take 120 grains daily for nine days afterward, it is evident that there was little toxic effect, either immediate or cumulative, exhibited in this instance. A calculation that I have made from the notes of this patient shows that he took about four and a half or five Troy ounces of hydrate of chloral during the first three weeks of his disease. Subsequently the amount was diminished steadily, and soon entirely discontinued.

Should the patient suffer a great deal of pain which the chloral fails to relieve, an occasional hypodermic of morphia may be administered, though I believe that, as a rule, large doses of chloral alone will control the pain. It is said that opium, on account of its tendency to produce constipation, seems to be at times mischievous in the treatment of tetanus,* but, of course, occasional opiates would not be open to this objection. If the chloral causes looseness of the bowels, some astringent can be employed as an adjunct; but a single remedy is always preferable when we wish to derive a scientific conclusion as to the effects of a drug in disease, and hence it is much preferable to employ chloral, and chloral alone, in the treatment of tetanus. No remedy is known to cure this unmanageable affection, and, therefore, it is justifiable to give chloral a fair trial without complicating results by adding other agents.

A recent observer has treated tetanic patients by placing them in dark rooms and stopping their ears with wax, in order to exclude all outward influences tending to disturb the nervous equilibrium.* This, it may be presumed, is the mode of operating by which the chloral treatment proves beneficial, for its effect is to blunt sensibility to external impressions, and to induce a perfect repose of the nervous centres.

You may inquire whether the cases placed upon chloral have recovered. To this I can only say that many instances have been recorded where cure certainly took place during the administration of this agent, though it is true that other patients have succumbed, notwithstanding the employment of chloral in proper amounts. Again, it must be admitted that evidence has been adduced, showing cures following the exhibition of opium, physostigma and woorara. In reply, however, it may be retorted that one or other of these remedies would have gained the reputation of being the specific for traumatic tetanus long ere this, if the cures had been more than mere coincidences in a few cases. Chloral, however, deserves great consideration, because its youth in the medical family has prevented a full trial of its virtues as an antagonist to tetanus. Hence it is rational to test its power in every instance, rather than to depend upon the older drugs which, though before the profession for many years, have failed to establish any claim of their own in similar cases. Some years ago, fifty-four cases of traumatic tetanus treated by chloral were reported, of which thirty recovered.† This was over fifty per cent. of cures. In one of the hospitals of this city there occurred, in four years, nineteen or twenty cases of traumatic tetanus, all of whom died except three. These three patients had been treated with chloral throughout the disease.‡

These circumstances, combined with what I have seen of the effect of chloral in affording relief to tetanic pain and rigidity, have induced me to look upon this medicine as a valuable

†"Surgery. Its Principles and Practice." T. Holmes. pp. 58. English Edition.

*Centralblatt für Chirurgie, No. 41, 1877.

† H. C. Wood's Treatise on Therapeutics, pp. 292-293.

‡ *American Journal Medical Sciences*, October, 1877

remedy in traumatic tetanus. In fact, it also appears to me to be a proper antidote, and one which I would certainly administer in the tetanoid convulsions resulting from strychnia poisoning. It is possible that it might be of some service in hydrophobia, if given in a similar manner from the very incipiency of the symptoms.

I shall close this paper by giving an abstract of the histories of two cases treated by chloral, merely to show the course of the disease and the method of administering the remedy.

W. T., a boy of nineteen years, was treated by Dr. Levis for a gunshot wound of the left arm, produced by the discharge of a fowling piece, which tore away a considerable portion of the inside of the arm and forearm. On the fourteenth day tetanus declared itself by trismus and abdominal rigidity, which were soon followed by opisthotonos and spasmodic contraction of the masticatory muscles, causing laceration of the tongue. The amount of chloral given averaged one hundred grains in twenty-four hours. Amputation of the limb was discussed, but deemed inadvisable, and the treatment was limited to chloral, with occasional opiates when he complained of great pain. As stated above, I believe this could probably have been dispensed with if more chloral had been given. In ten weeks the patient was able to be up, and speedily convalesced.

The following case, treated by Dr. Hunt, is still in the Pennsylvania Hospital.

Barney McD., aged 21 years, was admitted April 23d, 1878, with a large lacerated and contused wound of the sole of the right foot, sustained by jumping from a railway train. The skin and superficial fascia of the sole sloughed, exposing the plantar fascia; and the man soon exhibited the sardonic expression, the trismus, and the abdominal rigidity of tetanus. He was placed on chloral and received about one hundred grains a day. He was, in addition, kept quiet, in a darkened room. The jaws could only be opened about half an inch, and there was some opisthotonos and delirium. It is stated by the nurse that the spasms threw him out of bed on two occasions, but it is questionable whether this is the fact, as he may have jumped up while in a delirious condition. On June 4th, which was about one month from the onset of tetanic symptoms, the rigidity had almost subsided; and a few days ago, when I saw him, the patient was to all intents and purposes well. At the same time the wound had almost cicatrized.

This certainly presents the features of a case of subacute tetanus, which we know is more amenable to treatment than the severer form, but may not chloral have had something to do with rendering the affection lighter in its nature? At any rate, I hold that this method of dealing with tetanus is worthy of a more extended trial.

OPERATION OF TREPHINING.

BY JAMES L. PERRYMAN, M. D.,
Of Belleville, Ill.

I was called to see Mr. William Williams, a coal miner by occupation, who had his skull fractured by the premature explosion of a blast in a coal mine, the point of fracture commencing a little above the left frontal eminence of the frontal bone, extending to the opposite side and down to within half an inch of the nose. There was about a tablespoonful of the brain that had oozed through the wound. It was a compound comminuted fracture, with depression of the bone and compression of the brain. The patient being in convulsions, I suggested to my friend, Dr. Moore, who assisted me, to put him under the influence of chloroform. I then shaved the scalp, cleansed it, and made a V-shaped incision, so as to include the fracture and a portion of the sound bone, and then applied the trephine. After the crown of the instrument had passed through the external table and diplöetic structure, I rotated the trephine a few times upon the vitreous or internal table of the skull, bending the instrument gently backward and forward, breaking out the piece that was inclosed in the crown of the instrument, thereby preventing any possibility of wounding the dura mater with the teeth of the saw. I have practiced this mode of procedure in several other cases with good results, and I believe, from the experience that I have had, that it is by far the safest mode of operation. For it is extremely difficult, as every surgeon of experience knows, to trephine the human skull without wounding the tissues beneath. I am not unmindful of the fact that such a mode of procedure is unauthorized by those who have taught and written most about surgery. With the elevator I raised the depressed bone, and succeeded in removing several fragments of the osseous tissue. The membranes of the brain

were wounded, and, as I before remarked, a tablespoonful of the brain had escaped through the wound. After the removal of the fragments of depressed bone, the patient passed rapidly from under the influence of the anæsthetic. His convulsions ceased promptly, pulse full and strong, sixty-four to the minute, respiration less stertorous and more natural, and in about an hour after the operation he spoke coherently, but in monosyllables.

We prescribed thirty grains of calomel, to be taken as soon as the patient could be induced to swallow it. Ordered ice in a bladder applied to the head. Saw the patient next morning, the calomel having acted properly; pulse full, more natural, seventy per minute; respiration easy and regular; mind clear; consciousness completely returned. During the day took beef tea and milk. I prescribed three grains of quinine every four hours. On second day saw the patient with all his symptoms improved and wound looking well. Continued to improve without any untoward symptoms until complete recovery had taken place. Convalescence reaching over a period of about twelve weeks. It is now two years since the occurrence of the accident. I send you a photograph of the patient after complete recovery.

About a year ago I was called to see Mr. ——, aged thirty, who is also a coal miner by occupation, whose skull was fractured by a piece of coal falling upon it about an inch and a half or two inches above the left eye, about the junction of the squamous portion of the temporal bone with the frontal. I shaved the scalp and made the usual V-shaped incision, including a portion of the uninjured bone and the fractured portion. This patient also was in convulsions. Drs. Moore and Stookey administered chloroform. I applied the trephine, as detailed in the preceding case. Took the elevator and raised the depressed portion of the temporal bone. The anæsthetic soon passed off, leaving the patient quiet; convulsions ceased; pulse sixty; respiration free. Prescribed thirty grains of calomel and ordered cold applications to the head. Next day found the patient perfectly conscious; respiration free and easy; pulse seventy-two per minute; took nourishment. Prescribed for him three grains of quinine every eight hours. Continued the cold applications. These patients recovered completely, with no loss of mentality and no paralysis. I have been induced to prescribe quinine for all my surgical patients, from the fact that we are living in a malarious district. I think it greatly lessens the danger of tetanus and erysipelatous inflammation.

Hospital Reports.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

CLINIC FOR DISEASES OF THE NERVOUS SYSTEM.

BY PROF. C. C. SEGUIN.

Reported expressly for the Medical and Surgical Reporter.

Paralysis of the Serratus Magnus Muscle.

Gentlemen:—You remember that a short time ago we had at the clinic an example of a very rare paralysis, viz., that of the serratus magnus muscle, occurring in a child seventeen months old. Curiously enough, a few days afterward I was called in consultation, to see a precisely similar case. This was also in an infant, the child being about a year old. It had been in apparently good health, when one morning it was suddenly noticed that it could not (or at all events did not), lift up its right arm. The family physician was not called in for two days, and by the time he saw the child there was nothing wrong about the arm or shoulder, as far as he was able to make out. In the course of a few weeks, however, the same difficulty returned, and then the physician discovered that, although the shoulder joint was perfect, there was a deformity about the scapula. He sent for me to see the case with him, and when I came to make an examination I found the upper shoulder muscles all acting well, but discovered that the point of the shoulder had fallen somewhat, while the posterior border of the scapula was quite widely separated from the chest wall. The characteristic deformity known as the "winged scapula" was thus presented, in the same perfect manner as in the little patient whom you recently had the opportunity of seeing at the clinic.

In order to make the diagnosis complete, I applied the faradic test. I first tried the right, or unaffected, side, placing one pole of the battery in the axilla, and the other just behind the posterior border of the scapula, when the base and inferior angle of the latter were drawn forcibly forward, thus showing that the action of the serratus was perfect. When the current was applied to the corresponding parts on the other side of the body, however, no such action was produced, and the seat of the trouble was at once conclusively demonstrated.

When the arm was in action, the scapula at once followed all its movements, in the most complete manner, there being precisely the same unnatural mobility about the scapula as

in the case which you saw here. Both of these cases I saw within a week, and it is one of the most remarkable coincidences that have, as yet, occurred to me, since they are the only ones of the kind that I have ever met with. You will not find this paralysis described in any of the books.

Hemiplegia from Cerebral Hemorrhage.

The patient now before you, aged fifty-six years, was taken with paralysis of the whole of the right side in May, 1877. His wife says that before retiring, on the night in which the attack came on, he took a cold-water bath. About one o'clock in the morning he awoke her, and she found that he had great difficulty in speaking, that he could not swallow, and that his mouth was drawn in a very marked manner to the left side. Both the upper and lower extremity on the right side were also completely paralyzed; but the patient never lost consciousness, as far as can be ascertained. It was the first trouble of this kind that the man had ever had, and he has had no new attack since then.

He began to recover some motion in about three weeks (this occurring, as is the ordinary rule, in the leg first); and in three months he was able to walk about. There was no anæsthesia, but there was early contracture, which, however, has been steadily improving. At the present time we find that his memory is somewhat impaired, that speech is still more or less imperfect, and that the patient is inclined to be emotional, his wife telling us that he sometimes bursts into a fit of weeping without any apparent cause. Aphasia, as you know, is tested in various ways. One of them is to notice whether the patient is able to speak continuous sentences intelligibly. Another is to ask the patient to repeat the names of various articles indicated to him, and the mistakes thus made often point out the aphasia in a very striking manner. This is when it is of the "amnesic" variety. Here the aphasia is quite slight, although he does not get his numbers very correctly in giving his age, residence, etc. Still, we must not lay too much stress on that, as his wife informs me that "his memory for figures was always poor." He has had more or less muscular rheumatism, from time to time, but never any acute articular rheumatism, and, on examination, I find the heart to be apparently entirely normal, there being neither any murmur or unnatural intensity of the second sound. This, of course, you will understand, has an important bearing on the etiology of the brain lesion.

When the patient walks, you notice that he has the characteristic gait of hemiplegia. The whole side of the body swags, the shoulder falls, and the paralyzed leg is swung around in such a manner as to describe an arc of a circle. You see, also, that when he makes the attempt to raise first the arm and then the leg on the affected side, he succeeds much better in the latter case than in the former; thereby affording an illustration of the ordinary rule, that in hemiplegia recovery is much more marked in the lower than in the upper extremity. The very small degree of power recovered in the arm is also shown in the grasp of his fingers, which is exceedingly feeble. At present there are no symptoms whatever of paralysis about the face. In these ordinary cases of hemiplegia there is usually no impairment of sensibility, the paralysis being entirely motor; and in the present instance, on testing by the æsthesiometer, I find the sensibility quite fair for the skin of a laboring man. On testing for tendon-reflex in connection with the extensors of the thigh, I find that it is quite marked in the affected limb, but almost altogether lacking in the sound one. The same relative amount of reflex action is shown in the upper extremities (though in a less marked manner), when sudden pressure is made upon the tendon of the supinator longus, while the hand is in a state of relaxation. The eyesight remains very fair, although I have discovered, by the ophthalmoscope, a rather unusual appearance of the retina, which I am not at present quite prepared to explain.

We have here the ordinary history of a hemiplegic attack; but as it occurred in the night, it is impossible to determine now whether there was loss of consciousness at first or not. As to the seat of the cerebral hemorrhage giving rise to the paralysis, it must, no doubt, have occurred either in the left corpus striatum or else in what is known as the motor tract of the convolutions. It is not easy to make a diagnosis between the two, as hemorrhage into either part is followed by motor paralysis, and both early and remote contracture. Still, I believe that when the lesion is in the motor centres in the cortex, it ordinarily produces a slighter grade of palsy than if it is in the corpus striatum. The recovery of the patient will depend on the position of the hemorrhage and the amount of encroachment by it upon the gray matter. In the present instance the prognosis is somewhat unfavorable, because, as we have seen, there has been contracture continuing steadily from the first. Ordinarily there is an early contracture, which passes away in a few days, and a later contracture setting in in the course of six or eight weeks, with an interval of complete muscular relaxation between them.

The appropriate treatment here will consist of massage and the faithful application of electricity to the paralyzed parts, and the internal administration of strychnia and iodide of potassium. I do not think there is any special advantage in giving strychnia hypodermically, as is quite customary at the present day.

In presenting this case to you, you notice that I have not discussed the hypothesis of embolism. My reasons for excluding the probability of this etiology are as follows:—

First (and this is the most important point in this connection), because the heart is normal.

Second, because the attack occurred in the night, and embolism is much more apt to give

rise to hemiplegia during the daytime, when the patient is more or less actively engaged.

Third, because if such severe paralysis as has been present here had been due to embolism, the attack would, no doubt, have proved fatal.

Perhaps it may be of interest to discuss a little more fully the probable seat of hemorrhage in this case. The almost complete recovery from the aphasia which was noticed at first is decidedly in favor of the lesion's being in the corpus striatum; for if it had been in the cortex, I am quite positive that the patient would not have regained his power of speech as he has. It has been demonstrated that the seat of articulate language is intimately associated with the motor tract in the convolutions. Thus, the upper part of the third frontal convolution is concerned with motion in the lower extremity, and the portion below that with motion in the upper extremity; while the inferior part is connected with the cheek and mouth. Here, also, are the parts where the power of language resides. If the Sylvian artery be occluded, permanent aphasia results, and the doctrine now accepted is, that besides the speech *centre* there is a speech *tract*, injury to any part of which will produce more or less aphasia.

That there is a motor tract in the convolutions can no longer be doubted. When we come to examine the anatomy of the parts in the anterior portion of the cerebral hemispheres, we find that a portion of the fibres constituting the internal capsule (which are derived from the *crura cerebri*) pass between the intra-ventricular nucleus and the *nucleus denticularis* of the corpus striatum, and are distributed to the parts of the cortex which have been found to be associated with motor influence. The observations of Charcot in his pathological studies have shown that this tract is distinctly motor, and the same thing has been more recently demonstrated by physiologists by means of the galvanic current.

Contusion of the Ulnar Nerve.

This woman comes to us to get relief for the condition of her left hand, which, she tells me, always feels as if it were asleep. At New Year, she says, she got a fall, but having "taken a little too much," she cannot tell anything about the way in which she struck. When asked to point out the particular seat of trouble, you notice that she demonstrates quite accurately the distribution of the ulnar nerve. It is not difficult to see that there is considerable atrophy of the hand on the ulnar side, the interossei muscles especially being wasted. Now it is desirable to see how much muscular power remains. You notice, in the first place, that there is some action of the interossei, as the patient is able to abduct the fingers to a certain extent. For detecting the sensibility of different parts, the electric brush furnishes us with the most accurate method, and on applying this test here, we find that there is partial anæsthesia on the ulnar side of the hand, while the sensibility is unimpaired in the other portions. This would seem, then, to be a case of injury to the ulnar nerve, from the effects of the fall received at New Year.

But I find, now, that there may possibly be some ambiguity of diagnosis; for the patient tells me that when a child she met with a fracture involving the left elbow, and, from the appearance of the joint, it would seem not improbable that the ulnar nerve had been injured at that time by the callus thrown out pressing upon it. The woman states, positively, however, that her present trouble dates only from the fall mentioned, and, by means of the galvanic current I am enabled to exclude the old fracture as a cause. You perceive that the muscles of the forearm, which are supplied by the ulnar nerve, respond perfectly to electrical stimulus, and this shows, conclusively, that the injury producing the symptoms noted cannot be located so high up as the elbow. It is found that the right hand is decidedly warmer than the left, and on applying the interrupted current to the affected hand, there is seen to be almost complete loss of faradaic motion by the interossei.

This is the second case of the kind which I have been able to show you during the present course; and the other patient is still under treatment at the Manhattan Hospital.

In that, you remember, there was an injury to the carpus, which produced a contusion of both the ulnar and median nerves, and it was characterized by numbness, partial anæsthesia, wasting, paralysis and loss of faradaic motion. The improvement, under treatment, has been very satisfactory.

In the present instance the case is interesting principally as regards the ambiguity of diagnosis, which, I think, I have sufficiently illustrated. The patient says that her left arm has never been very strong, and this we can readily understand from the very extensive injury which the elbow joint seems to have received from the fracture long ago. We have seen, however, that the present trouble about the hand must have had its origin in the comparatively recent fall. True arthritis may produce great muscular atrophy; but this is not the case when there has been traumatic injury to the joint. I believe the woman can be cured, for I do not think that the ulnar nerve has been divided, but has only suffered a contusion; because the anæsthesia of the parts supplied by it is incomplete. In some individuals only the little finger on the dorsal side is supplied by the ulnar nerve; but here the more extensive anæsthesia and wasting shows that the patient has the more common distribution of the nerve. The treatment will consist principally of the prolonged use of electricity and frictions.

The Diagnosis of Incipient Caries of the Vertebræ, from Disease of the Spinal Cord.

The next patient I have to show you to-day was at the clinic once during the past winter,

and we then came to the conclusion that the trouble from which he was suffering was an affection of the vertebræ, rather than of the spinal cord.

So impressed was I with the idea that the symptoms complained of were indications of beginning caries (although there was not the slightest trace of any spinal curvature), that I sent him to the Orthopædic Dispensary, in order that I might have the opinion of Dr. Shaffer in regard to the case. After making a careful examination of the patient, the doctor confirmed my views, and ordered an appropriate support for him; since which time the man has been improving in the most satisfactory manner.

Let me now run briefly over the past history of the case. In July, 1876, he suffered from a stricture, but this was completely cured by one of our best genito-urinary surgeons. About a year later he began to suffer from aching pains in the loins, in the left upper extremity, and from the left shoulder down the side and back. He complained of slight dizziness and occasional dysæsthesia in the lower extremities; that is, they would go to sleep after he had been standing upon them for a time. There was, however, no paresis, and no loss of coördinating power. The symptoms were not, indeed, pathognomonic of caries of the vertebræ, and yet this condition seemed to me highly probable, on account of the absence of paralysis, coördinating power and permanent numbness, as well as the presence of pain, such as is characteristic of "false neuralgia." It is called false neuralgia because it is not limited to certain areas, and is not paroxysmal in character.

Beside affecting the locations which were mentioned just now, the pain would radiate over the abdominal walls and down the thighs. Charcot has pointed out that pain such as this patient described is produced by some irritation about the roots of nerves, and here, as has been proved, we had Pott's disease, in which both the dura mater and the bones are affected.

In a typical case there is only one of these false neuralgias. In little children, for instance, there may be apparent colic existing for many months; but it is worthy of note that the pain is not movable, as in true colic. Or, again, the pain may be seated in the chest, the side, or the groin. It has been found always to be at a level corresponding with that of the disease in the vertebræ. In the present instance all pain has been removed by the instrument which the patient has been wearing.

It is a matter of great practical importance to be able to make the diagnosis of caries of the vertebræ before curvature has commenced. Some years ago it was not believed possible to do this, but at the present time, if in any case there is failure of the general health, associated with such neuralgic-like pain as has been described, and perhaps fever, we are certainly justified in suspecting commencing Pott's Disease. A skillful examination of the vertebral column will then probably detect a certain deficiency in mobility. In cases of doubt it is always well to consult a specialist in orthopædic surgery. Not long since I received a negative opinion from Dr. Shaffer, in a case of locomotor ataxia, in which I suspected the existence of incipient caries as a complication. The doctor found that the mobility of the spinal column was entirely normal, and hence decided that there was no caries; a conclusion which has seemed to be verified in the subsequent history of the case. In any case in which there should be a reasonable suspicion of caries after a thorough examination, we ought by all means to give the patient the benefit of the doubt, and see that a suitable support is provided for the spine. In regard to the exact nature of this support I have nothing to say, as it would be manifestly out of place here. Each one of you can decide for himself, in any given case, whether a properly constructed steel instrument, or the more recent device of the plaster-of-Paris jacket, will suit your patient best.

Editorial Department.

Periscope.

The Treatment of Typho-malarial Fever.

Dr. J. S. Caulkins, of Michigan, reports a number of cases of this disease in the Detroit *Lancet*, and gives the following remarks on treatment:—

From these histories, which are a fair average of the disease as it is here, at least, it would seem that quinia was imperatively demanded in its treatment; not, however, in the expectation, which experience has proved to be vain, of arresting it, but for its tonic power against the depressing effect of the colliquative sweats, by supporting the flagging motion of the heart. The remedy has been used by the writer, in moderate doses, to answer this indication—that is to say, in such as would cause some ringing in the ears. The antipyretic doses of Liebermeister, 30 to 45 grains, he has never ventured to try.

The use of the alcoholics would seem to many to be called for, and to be an actual *sine qua non* in this disease, on account of the slowness of the pulse and the general depression of the

system, but they have not, as a rule, been well borne. They confuse the head, and even when much diluted produce gastric distress. Doubtless there are cases where they will be better tolerated, and be productive of benefit; but there is no apparent criterion for this class of cases, and the medical attendant can only ascertain by trial whether or not wine or brandy is well borne by his patient. It is safe to say that in three-fourths of the cases of typho-malarial fever in country practice alcoholics are not needed. This statement will probably have a heterodox sound to some that appear to think that every sick person must be dosed with brandy or wine, but perhaps these people might change their opinions if they were compelled to change places with their patients.

Too much attention cannot be given to cleanliness. Owing to the drenching sweats, it is necessary to wash the patient often, and change the clothing and bedding, or he will be poisoned by his own excretions. As a general thing, warm or tepid bathing is safer and more agreeable to the sick than cold, which causes chilliness, with imperfect reaction, and liability to congestions of important internal organs.

It is an excellent precaution to observe the condition of the feet, which, owing to the feebleness of the circulation, are apt to be cold. Keeping them warm is another safeguard against congestion.

Coming to the all-important topic of the nutrition of fever patients, the opinion is expressed that the one article of diet which is worth more to them than all the rest is milk.

Equally vital to the welfare of the sick is good ventilation, and fortunately it is not, like food and cleanliness, entirely dependent on the caprice of friends and attendants.

The Detection of Feigned Insanity.

On this important medico-legal subject, Dr. W. H. De Witt writes, in the Cincinnati *Lancet and Observer*—

The physician may be called upon to examine persons who feign insanity. This has been practiced in all civilized countries and in all ages. The vagrant finds the asylum a far better and more inviting home than the jail or workhouse. The criminal, fearing the strong arm of violated law, assumes the garb of the imbecile, or raving madman, to shift his crime from his shoulder.

First of all, discover whether there can be any motive for feigning insanity; usually the examiner will experience little difficulty in determining the true nature of such cause. For if the disease is assumed, they are simply imitators, and as such they are generally ignorant of the peculiarities, symptoms, etc., of the form of insanity assumed, and must, therefore, of necessity, be very clumsy personators. Occasionally a talented, educated person will thus seek to escape, but usually criminals are found in the lower stratum of society. If the person pleads at the time he committed the act he did not know it, or was unconscious of it, or stoutly denies having had any connection with it, the examiner should then carefully investigate his previous history, learn whether he has been an epileptic, or suffered from any other form of cerebral disorder, and, finally, whether he has received any injury to the head, sufficient to disturb the mental integrity. If the examination develops the presence of epilepsy, it should contribute largely in his favor.

If, on approaching the patient, he should become loud and boisterous, remember that the real insane man, at the approach of a stranger, is generally quieter, and less demonstrative. It is a fact worth bearing in mind, that feigned insanity is always over-colored. If, as they frequently do, he assumes the role of the acute maniac, he will very soon exhaust himself and sleep, for none but a genuine lunatic can withstand the constant strain and excitement. In the early stage of acute mania, patients seldom sleep, unless under the influence of powerful hypnotics. A valuable means of diagnosis in such cases is to be found in the administration of certain medicines. In real or typical mania there is a certain insensibility or resistance to the action of drugs, such as opium, chloral and emetics. The quantity required to produce sleep, catharsis and emesis, in the malingerer, would produce little if any effect on the real insane man.

Non-Restraint in the Treatment of the Insane.

Dr. W. Lindsay closes a long article on this subject in the Edinburgh *Medical Journal*, with the following conclusions:—

Among the general results of my own observation, correspondence, and reading, are these:—

1. The use of mechanical restraint is advocated by at least ninety per cent. of physicians engaged in lunacy practice throughout the world.

2. The minority is not greater than is that of the general population who believe in and propagate such absurdities as spiritualism.

3. But the advocacy of mechanical restraint is one thing, its use another. For there are many strenuous advocates of its use who, nevertheless, in practice seldom or never have, or have had, occasion to use it.

4. What such advocates contend for is perfect freedom, both of opinion and action—unfettered liberty to employ or apply what they consider the best thing for a given patient under given circumstances, without reference to the current creeds of other people—to the tyranny of a false public opinion, or of a spurious public philanthropy, or to the amiable crotchets of mischievous enthusiasts.

5. The use of mechanical restraint is advocated, or it is itself employed, by the most eminent specialists of the day—by men as conspicuous for their advanced humanity or philanthropy as for their general culture and professional ability.

6. Mechanical restraint forms an occasional

feature of treatment in those asylums which have the noblest history and the highest reputation.

7. In other words, it constitutes an essential feature in the most modern, most enlightened, most humane treatment of the insane; while

8. It is itself unquestionably the most humane mode of treatment that can be adopted in certain exceptional circumstances.

9. One proof of this is to be found in the fact that maniacal patients themselves are sometimes the first to recognize its benefits by requesting its application, just as they voluntarily, in similar conditions, betake themselves to seclusion.

10. The substitutes that have been introduced by those whose extreme views have led them to renounce everything savoring of mechanical restraint are productive of much more serious and numerous evils.

11. So much so that Conollyism has done an amount of mischief to the insane, and to society through them, compared with which all the evils of the old restraint, in so far as those evils were at all real, are a bagatelle.

The Oxalate of Cerium in Pregnant Sickness.

Dr. Francis Edward Image writes to the *Practitioner*—Sir James Simpson introduced the oxalate of cerium, and prescribed it in ten-grain doses. The officinal dose is from one to two grains, which is, as a rule, so useless that the preparation has been stigmatized as the "oxalate of mud." As a general practitioner of seven years' standing, very many cases of pregnant sickness have naturally come under my care, and up to the present time I have not met with a case in which the nausea has not been very considerably relieved, and in most cases completely checked, by ten-grain doses of the oxalate of cerium. I have at the time of writing this a lady under my care, who, from the fourth week of her pregnancy till now, the eighth month, has suffered at intervals from this distressing symptom, but whose sickness has been invariably checked by from two to three days' administration of the oxalate in the dose I have mentioned. In severe cases I give it every four hours for the first day, beginning the first dose half an hour before the patient rises, and then, as improvement takes place, diminishing it to three times a day, but always giving the first dose of the day before the patient moves from the horizontal position—a point to which I attach much importance. The formula I employ is—

℞.	Cerii oxalatis,	grs.x	
	Pulv. trag. co.,	grs.x	
	Tre. aurantii,	℥ss	
	Aquam. ad.,	℥j.	M.

In Dr. Frowert's case he prescribed 1½-grain doses, which were "not followed by the slightest remission of symptoms." I hold that this want of good result was from the insufficiency of the dose.

The oxalate of cerium I have also found most efficacious in restraining the nausea resulting from uterine irritation. I generally combine it with bromide of potash in these cases, but have found it succeed in combination where the previous employment of the latter drug by itself has been without appreciable effect.

On the Use of Oil of Turpentine and Lucca Oil in Typhoid Fever.

Dr. P. L. O'Neile, Physician to the Fever Hospital, Athy, says, in the *Practitioner*—

In the April number of the *Practitioner* there appeared an extract from a communication of Doctor Perssé White to the *Medical Times and Gazette*, in which he extols oil of turpentine as a remedy in bronchitis complicating typhoid fever. I can endorse his remarks, and at the same time add that oil of turpentine, combined with lucca oil, in the proportion of fifteen minims of the former to thirty or more of the latter for a dose, and made up with mucilage or the yolk of an egg, is the best remedy for the diarrhœa and tympanites which are generally associated with the typhoid which prevails here at present. In the extensive practice which I enjoy, I have found this combination superior to any other drugs. Under its influence the stools are reduced in number, and become more solid in consistence, and the tympanites gradually less. In only a few patients have I known its administration to be attended with disagreeable results to the stomach, the greater number manifesting a wonderful tolerance of it. It may be given three or four times in twenty-four hours, and continued for weeks, if necessary. It prevents the palpable wasting of the disease, and obviates the necessity of giving alcoholic stimulants to a great extent—no mean desideratum in a workhouse institution.

Suicides Among Prisoners.

The *Journal of Mental Science* states that Dr. Morselli has made an elaborate analysis of the statistics of suicide in the Italian prisons, of which the main points are as follows:—

1. The frequency of suicide and attempted suicide is greatest in prisoners between 21 and 30; while in the population at large its frequency is greatest after forty years of age. Probably the young feel confinement most.

2. Suicide is committed or attempted more frequently in prison by country people than by townspeople; this is the opposite of the rule for the country at large.

3. Nearly half the attempts at suicide (as is also true of the attacks of insanity) are made within the first year of imprisonment.

4. Twenty-three per cent. only of those who attempted suicide had been condemned to less than five years' imprisonment.

5. Two-thirds of those who attempted suicide had always been reported as well-conducted in prison.

6. The proportion of suicides in Italian prisons is lower than in other European countries for men; but the proportion in women is relatively higher.

7. Suicides are more frequent during the summer months than in winter.

8. There is no evidence that in Italy suicides are more common in prisons on the cellular system than in others.

Morselli is strongly of opinion that Dr. Nicholson rates much too highly the proportion of simulated attempts at suicide to the real ones.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

—Dr. L. Turnbull's work on Anæsthesia has been very well received by the medical press. The eminent Dr. B. W. Richardson remarks of it, in a letter to Dr. Leared, "It is a good work, prepared with much conscientious care."

——"Dr. Stoker," says the London *Academy*, "is engaged in writing an account of his experiences in European and Asiatic Turkey during the late war. Besides serving in the Turkish army in the Caucacus, the Shipka Pass, etc., Dr. Stoker was for some time engaged in assisting Lady Strangford in her work, and he, therefore, had ample opportunities for observation."

——Dr. J. V. Shoemaker, of this city, has prepared a handy "Revised Chart of Skin Diseases," giving names, characters, and changes of their lesions. He has also prepared a chart of materia medica as taught in Jefferson Medical College, of value to students.

BOOK NOTICES.

The Antagonism of Therapeutic Agents, and What it Teaches. By J. Milner Fothergill, M.D. Philadelphia, H. C. Lea, 1878. pp. 157.

To this essay the Fothergillian Gold Medal of the Medical Society of London, for 1878, was awarded, and it will be found a highly interesting study and practical application of the antagonistic action of certain drugs. The author commences with a rehearsal of a number of experiments, mostly by other hands, illustrating the antagonism of opium and belladonna, atropia and prussic acid, atropia and physostigma, chloral and strychnia, chloral and picrotoxin, aconite and digitalis, etc., both in the lower animals and in clinical experience. Two chapters are then given to the antagonistic effects of drugs on what the author chooses to term "the rhythmically discharging centres," by which mysterious expression we find he means the circulation and respiration. The practical use of the antagonism of drugs in cases of poisoning presents itself as an important part of his inquiry, and is ably handled. The last chapter, on the use of the antagonism of drugs in ordinary practice, is less satisfactory, as the cases mentioned are not very convincing, and the author acknowledges to have formed some of his "views" so recently that he has not had an opportunity to bring them to the test of practice. Still, his words are suggestive.

Elementary Qualitative Analysis. By Alexander Classen. Translated, with additions, by Edgar F. Smith, A.M., PH.D. With thirty-six illustrations. Henry C. Lea, 1878. 1 vol., 8vo, pp. 328.

The short treatise of Classen has met with much popularity on the Continent, on account of its clear statements, brevity and judicious selection of methods. For a handy book for quantitative determinations it hardly has its superior, and it is enough to say that it stands where Fresenuis' work did some years ago. The translation, by Dr. Smith, has been accurately made, and the pages are illustrated with a number of engravings of apparatus. The paper and typography are excellent, and no doubt the work will be well received by students.

Bibliotheca Medica. A Catalogue of American and British Books relating to Medicine, Surgery, Dentistry, and kindred subjects. Cincinnati, Robert Clarke & Co., 1878. pp. 244. Price 25 cents.

This second edition of Robert Clarke and Co's. Catalogue contains quite a complete list of books and periodicals devoted to medicine, pharmacy, and kindred sciences. It would have been more useful if the publishers of the books had been mentioned, an omission which we can only explain on small-minded trade reasons. Of course the lists, though full, are not exhaustive. Naturally turning at this time to authors on yellow fever, we notice that Dowell and Belot, the two most recent authors, are neither of them mentioned in this connection.

THE

Medical and Surgical Reporter.

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

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115 South Seventh Street,
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THE CHINESE QUESTION IN ITS MEDICAL BEARINGS.

It is always to be sincerely regretted when scientific men misuse facts in order to bolster political and social prejudice. We cannot but regard in this light some of the recent expressions of the California medical press in regard to the Chinese. Everybody knows that the jealousy of the rabble and the discreditable enmity of the "hoodlums" (*who have votes*), have so infected the political parties of that State, that hardly a man is to be found there honest and bold enough to stand up for the principles for which this free government was founded. They are all willing to deny and renounce the one great foundation principle of our Declaration of Independence and Constitution, at the beck and order of the lowest and narrowest class. The Christian religion and the natural freedom of man are declared to be unable to withstand the introduction of Mongolian emigrants!

That even medical men should cater to this nothing else than contemptible subserviency (or disgraceful cowardice), we did not expect; and were, therefore, painfully surprised to find the *Western Lancet*, in a long editorial, some months ago, trying to stir up and disseminate this prejudice, not only in California, but elsewhere in this country. It prints an appeal on the subject, to which we give the benefit of circulation. After speaking of the number of prostitutes in San Francisco, "mostly young girls of the Mongolian race" (in passing, we add, that there is very positive authority for saying that the majority of prostitutes in San Francisco are *not* Mongolians), and that, of course, syphilis is common, the writer proceeds—

"While the labor question may engage the attention of the community, legislators, and the nation at large, the subject of social evil, and the engrafting of formidable types of disease on our race, should occupy the attention of medical men.

"Leprosy is another of the gifts of Asiatic civilization to mankind, and are we to lie idle and allow this to be engrafted on the future generations that will occupy our places when we have paid the last debt to nature? We trust that the medical men of this State and the adjoining States will give these subjects their attention, and carefully follow up the suggestion, tracing to their origin many of the sad cases of necrosis, tubercle, paralysis in all its varied forms, and the multitude of hydra-headed marks that this foul disease entails on man when contracted in early life. Also, whether there is not a specific difference in the type of disease which is introduced from the Mongolian race and that with which the Caucasian race has been afflicted for ages, under the rule of indiscriminate intercourse."

Now, *we trust* that this utterly groundless appeal to the passions and prejudices will meet with the condemnation it deserves. There is notoriously not the slightest basis for the assertion that "Mongolian syphilis" is one whit worse than the genuine native American article. The reports of the British Hospital, at Hong Kong, for many years past, are printed and easily accessible, and prove the falsity of the charge. The assertion that, because leprosy finds its historical origin in Asia, we should forbid all Asiatics our shores, shows the narrowness and worthlessness of the anti-Chinese arguments.

Leprosy is, and has been, more prevalent in western than in eastern Asia. Especially severe has it been in Judea, whence, however, we have another "gift of Asiatic civilization," to wit, the Bible, which teaches us the brotherhood of man, and specifically that, if a man is a leper, or a woman a Magdalen, we should not, on that account, shut our doors to them and forbid them our presence. Yet, just this is what this specimen of American civilization calls upon the profession whose mission is the healing art, to do.

The whole anti-Chinese agitation is an outcome of the worst and lowest enmities of selfish class strife; it has been fostered by narrow-minded or unscrupulous demagogues, in order to catch the votes of the masses; it has extended by a contagion of mistrust and bigotry far more to be feared than leprosy, to the cultivated, even the philanthropic, few. Now that it is deliberately urged on the medical profession, this journal pronounces on the position it shall take, in language of no uncertain ring. The Chinese ought to receive as warm a welcome throughout the whole of this broad land as the German, the Irishman, the Englishman, or the African. Our gates should be opened to him without restriction; his comings and goings should be aided and encouraged; the selfish classes who would abuse him, and the blinded men of education who berate and falsify about him, should alike be repressed—the one with the prompt and strong arm of the law, the other with the open and general condemnation of their enlightened compeers.

Notes and Comments.

Bills Presented.

Bills will be found enclosed in this and the last numbers of the Reporter, to those who have not yet settled their indebtedness to this office. We fully believe that, in nearly all cases, this neglect is owing to forgetfulness and the pressure of other occupations. And we hope that this reminder will be sufficient to lead to a prompt adjustment of these accounts.

Yellow Fever.

Our esteemed correspondent, Dr. A. R. Kilpatrick, of Texas, writes us—

I am pleased that you give place, in your very popular Reporter, to communications on the epidemic yellow fever. In the number for 31st of August, 1878, I read with great interest the views of Dr. J. M. Woodworth, Surg. Gen. etc. These views coincide with my own so well that I take pleasure in endorsing all except that the "period of incubation of the disease lasts from *two to six days.*" I have practiced in yellow fever cases since 1839, and have known cases where persons have had yellow fever after being absent from an infected place *twenty-one days.* From two to six days is the most general period of incubation.

I cannot believe in the local origin of yellow fever, and the proofs adduced by Dr. Woodworth are irrefragable, as to its being an exotic.

The Cause of Leukemia.

In the *Deutsches Archiv. für Klinische Medicin*, August 20th, 1878, Dr. Naumann has an article setting forth the grounds for believing that leukemia takes its origin in a disturbance of the functions of the liver, consisting in an overloading of the blood with albumen and its derivative forms, which do not undergo normal changes in the liver, especially the transformation into fat. From this theoretical discussion he advances the suggestion that, from the known effects of phosphorus on the hepatic functions, it is possible that this drug may prove curative in leukæmic cases; and in view of the notoriously intractable character of the disease, it is worth a trial.

Inebriety in American Women.

The editor of the *Journal of Inebriety* says, in a late number—

By many observers it is thought that the peculiar mental and nervous strain incident to the rapid changes of circumstances and condition common to American women predisposes them to inebriety. This is true to a limited extent only; relief from this condition is more often sought in narcotics, such as opium, etc.

From a general survey of the more active causes, it is evident that inebriety exists to a considerable extent among all classes of women in this country; also, that it is less prominent than in men, but more precipitate and rapid in its progress.

Pronunciation.

A correspondent throws out some hints on the pronunciation of medical terms. He writes—

It is to be regretted that physicians are not more uniform in the use of language, as regards pronunciation. It may be generally accepted as a fact that the physician who does not pronounce medical terms correctly has never had the advantages of a college education; for surely, if he had ever listened to medical lectures, he would know how to pronounce medical words. Unfortunately, there is a diversity among our professors in this respect; and more unfortunate still is the fact that our medical dictionaries afford us no guide. The rule that the accent falls upon the syllable containing the letter *o* in a large number of words, such as abdomen, clitoris, collodion, lithotomy, melanosis, etc., is generally observed; but the most striking lack of uniformity is in the use of the affix signifying inflammation. It will be noticed that the older members of the profession, those who do not like to be disturbed by what they term "non-essential innovations," retain the sound of *e*, while the young men, fresh from college, take delight in giving stress to the *i*, as it sounds in itis. The young men are undoubtedly correct, and it is a matter of surprise that Prof. E. M. Avery, of Cleveland, Ohio, in a recent work on Natural Philosophy, should take pains to continue an error by directing that liter should be pronounced 'leeter.' Aside from philological reasons, there should be as wide a difference as possible in pronouncing meter and liter, words which bid fair to come into general use, as errors would thereby be prevented."

To the above we would say that the pronounciation of Latin is differently taught in Harvard and Yale, and in Oxford and Cambridge; and while these great universities adopt such contrary methods, medical men are at liberty to follow which they please. Correct *quantity* is all that need be aimed at.

How to Kill a Tapeworm in an Hour.

Kousso and kamala are expensive drugs, nauseous to the taste, not always effectual, and requiring several days to effect the death of the worm. Dr. Karl Bettelheim, of Vienna, narrates, in the *Deutches Archiv*, just received, a heroic method and nearly sure cure in the short space of time of three quarters of an hour to two hours. It is this; he inserts a tube in the œsophagus, to the stomach, and pours down from 200 to 400 grammes of a very concentrated decoction of pomegranate root, having previously had his patient fast for 24 hours. The worm is stupefied and passed, head and all, to a certainty; the patient has no sickness of the stomach, and no nauseous swallowing to do; and the drug is cheap.

Ergot in Trichina Disease.

Dr. Rohde relates, in the *Berliner Klin. Woch.*, a case of trichinosis in which severe bleeding of the nose occurred, and in which he prescribed extract of secale cornutum as a styptic. The hemorrhage was immediately arrested, and with this rapid improvement of the general symptoms also occurred. This result led him to prescribe ergot in other cases of the disease; and in all instances distinct improvement followed. He believes, therefore, that we have, perhaps, in ergotin a means of treatment which, without having any marked effect on the human economy, may prove fatal to trichina and their offspring.

Laudanum Tippling.

The following extraordinary statement is from the *Journal of Inebriety*, for September. We can scarcely credit that it is extensively done:—

Our attention has been called to the fact that the use of laudanum as a drink was increasing in many parts of the country. Correspondence with patients and their friends furnishes many instances where laudanum is taken at soda fountains, and over the "bar" of liquor dealers, as a daily drink.

In most cases it is used with alcohol, to lessen the irritative effect of this drug, or the results of excessive abuse, as a sedative, or as a stimulant. In England a favorite preparation used after drinking is called "Pick me Up." In some large cities druggists give compounds of laudanum and ginger, under fanciful names, and these are resorted to always after, in place of, alcohol. This accounts for the enormous sales of opium, of which not over one-fifth is used in medicine.

—It is said that for six years, at least, no case of typhoid fever has been known to originate in the Philadelphia Almshouse, and a physician attributes the fact to the liberal use of copperas at the institution.

CORRESPONDENCE.

Yellow Fever in the Ohio Valley.

ED. MED. AND SURG. REPORTER:—

I notice in your issue of August 24th, just received, a paragraph concerning "Yellow Fever and its Rational Treatment," containing a misstatement calculated to do great injury to the medical colleges of this city. The paragraph leaves the impression that the disease is epidemic here, and that hundreds of cases have occurred. A statement of this sort just now, at the season when medical lectures commence, is calculated to divert students to other points. Yellow fever is not now prevailing in Louisville, and never has become epidemic, though at various times within the last thirty years cases have been brought here from the South and nursed by the citizens; in not a single instance have any of them contracted the disease. The City of Louisville has provided a fever hospital, and placed it in charge of an experienced physician, to which all cases developing among the refugees are at once taken. Eight cases in all have developed, in persons coming from Grenada, Memphis and Vicksburg, and of these, two have died. Two of the cases occurred in a crowded hotel, yet none of the inmates contracted it. Louisville never has been in a better sanitary condition, and the rate of mortality has been lower this summer than was ever known before. I trust that you will make this correction.

FRANK C. WILSON,
Secretary Hospital College of Medicine.
Louisville, Aug. 26th, 1878.

[We insert the above, although the paragraph alluded to does not bear the construction put upon it, and, of course, the medical profession read the papers enough to know that, so far, Louisville has escaped the epidemic.—ED. REPORTER.]

Naphtha as a Disinfectant.

ED. MED. AND SURG. REPORTER:—

As I have never seen the use of naphtha mentioned in any of the current medical journals, as a disinfectant, I desire to call attention to it, and seek, through your pages, any information other physicians may have, as to its use in sick rooms and for the purpose of disinfecting all clothing, hangings, bed clothes, books, furniture, etc. Having had some experience in its use, and believing in its efficacy, I should like to hear from any physician who has experimented with it. The only record I can find of any ob servation in regard to it, is by Dr. Day, of Melbourne, who has used gasoline, kerosene, naphtha, benzine and other products of petroleum, for disinfecting purposes. He considers naphtha or gasoline the best thing he has used, and attributes their disinfecting qualities to the fact that they possess the property of generating peroxide of hydrogen, or of storing it up until brought in contact with oxidizable substances for which it has an affinity.

Dr. Day suggests the brushing of books, wall paper, newspapers, which have been kept in the apartments of patients afflicted with scarlet fever, small pox, diphtheria, etc., with naphtha. Here, in Chicago, naphtha is used in an establishment which makes a speciality of cleaning carpets, furniture, mattresses and hangings, and especially the removal of moths. The furniture, carpets, etc., are dipped into tanks of boiling naphtha, and allowed to remain over night. Not the slightest injury is done the most delicate fabric, if we except the faint odor, which, after drying, is readily removed by proper airing. It is quite customary for some physicians here to send the entire contents of a sick chamber, carpet, curtains, furniture, books, papers, pictures, in fact, everything movable, and have them all placed in the tank for several hours. The naphtha is heated to a boiling point by steam pipes passing through the liquid, and although naphtha boils at rather a low temperature, 195°, or thereabout, the heat is considerably increased by the use of sheet iron covers to the tanks. In all the cases I have known of, it has proved a perfect disinfectant.

Just at this time, when the postmaster of Memphis has sought, through Surgeon General Barnes, some method of disinfecting the mails, it occurs to me that no way can be more expeditious, and none more reasonably sure, than that which I would suggest, of throwing the mail bags into one of these tanks filled with boiling naphtha. An hour's immersion would probably suffice to thoroughly disinfect them; the contents can be spread out and dried in half an hour, and in this way but slight delay would be caused in forwarding mails from southern points. L. H. WATSON, M.D.

Chicago, Ill., August 28th, 1878.

Etiology of Yellow Fever.

ED. MED. AND SURG. REPORTER:—

We wish, through the columns of your valuable journal, to moot the question in reference to the etiology and pathology of yellow fever, well aware of the fact that no disease has been more ably written upon than it has been. We have been taught, from time immemorial, by the ablest members of the profession, that it is a malarious disease, differing from intermittent and remittent fever only in degree, not in kind. Now, if this be true, is it not logical to suppose that the same remedies that cure remittent and intermittent fever should cure yellow fever? But our southern medical brethren, who are as skillful and learned as the members of the profession anywhere, have signally failed to stay its ravages in any degree. The treatment in no two epidemics being alike, in short, it has been empirical and experimental in the extreme. May we not be partly or altogether mistaken in reference to its etiology and pathology. If it is a malarious

disease, may it not be complicated with some other septic poison, analogous to that of typhus, or the materies morbi of some new disease not yet discovered? At this time we only wish to raise the question, without attempting its discussion. A thorough discussion and study of the disease by the medical profession of the whole civilized world, at present, would not be time misspent. JAMES L. PERRYMAN, M.D.

Belleville, Ill.

NEWS AND MISCELLANY.

American Academy of Medicine.

The third annual meeting of the American Academy of Medicine will be held in Pardee Hall, Easton, Pa., September 17th, 1878, at 3 o'clock P. M. R. M. SIBBET, M.D., *Secretary., Carlisle, Pa.*

FRANK H. HAMILTON, M.D. L.L.D., *President,* 43 *West 32d St., New York.*

September 2*d*, 1878.

American Gynecological Society.

The third annual meeting of this Society will be held in Philadelphia, September 25th, 26th, and 27th, 1878. Dr. William Goodell is president, and will deliver the usual address. Attention is called to the vote passed at the last meeting, "That all Fellows be henceforth limited to thirty minutes for the *reading* of their papers," which, however, does not restrict the length of the manuscript for publication. The meeting will be open to all members of the profession.

Official Yellow Fever Report for Week Ending Sept. 7th, 1878.

NEW ORLEANS.—During the week ended yesterday noon there were 1732 cases of yellow fever and 526 deaths, making in all 4609 cases and 1395 deaths. During the twenty-four hours to noon yesterday there were 280 new cases and 61 deaths.

PORT EADS, LA.—During the past week there was one death from yellow fever, but no new cases.

MORGAN CITY, LA.—During the week to yesterday noon there were 14 cases of yellow fever and 2 deaths, making in all 22 cases and 6 deaths.

VICKSBURG.—During the week ended yesterday evening there were 181 deaths, 41 of which occurred in the last twenty-four hours, making in all 366 deaths. About 2500 cases have occurred since the outbreak. Surgeon Keyes telegraphs that the fever is on the increase, and it is impossible to obtain accurate data.

GRENADA.—Dr. Warren Stone reports 96 new cases of yellow fever and 49 deaths during the week ended yesterday evening.

CANTON, MISS.—During the fortnight ended yesterday noon there were 172 cases of yellow fever and 22 deaths, making in all 190 cases and 30 deaths. There are 120 cases under treatment, of which 16 occurred during the last twenty-four hours.

OCEAN SPRINGS, MISS.—During the week ended yesterday evening there were 15 cases of yellow fever and 5 deaths.

HOLLY SPRINGS.—The first case of probable yellow fever occurred on the 27th of August, resulting in death September 1st; 2 deaths from undoubted yellow fever followed on the 2d. To yesterday evening, about 100 cases and 25 deaths had occurred. More than one-half of the population fled the city between the 2d and 5th instant. All of the members of the Board of Health are sick.

MEMPHIS.—For the week ended Thursday evening, September 5th, there were 529 deaths from yellow fever. Dr. Thornton reports that the number of cases cannot be obtained. During the week before the number of deaths (241) and the number of cases (721) were as 1 to 3.

HICKMAN, KY.—The first case of yellow fever occurred August 16th. There were 60 cases and 24 deaths to yesterday evening.

LOUISVILLE.—For the week ended yesterday evening there were 25 new cases of yellow fever and 7 deaths, all refugees and river boatmen.

ST. LOUIS.—During the week ended yesterday evening there were 3 deaths from yellow fever; 2 refugees and a resident nurse who attended the refugees in hospital. At quarantine, below St. Louis, there were 10 new cases admitted, and 9 deaths, all refugees but one—the steward of the quarantine hospital, who is now sick, he having contracted the disease at quarantine. All boats and trains from infected districts are prohibited from entering the city, which remains healthy.

PASCAGOULA, MISS.—3 cases of yellow fever, in shipping from New Orleans, between the 1st and 5th instant.

CINCINNATI.—From August 28th, to afternoon of September 4th, three new cases of yellow fever, and two deaths occurred, among refugees.

BAY ST. LOUIS, MISS.—One refugee arrived from New Orleans, August 26th, with yellow fever, and was sent back to New Orleans the next day. No other cases.

MOBILE.—City healthy. No yellow fever since the one death which occurred August 31st.

KEY WEST.—Two cases of yellow fever and one death during the week ended yesterday noon. JOHN M. WOODWORTH,

Surgeon General U. S. Marine Hospital Service.

—Dr. Joseph Kidd, the physician who was summoned from Berlin to attend Lord Beaconsfield, charged one hundred guineas a day for the period of his absence from his patients. His practice is said to be worth more than that. Some of the newspapers speak of him as a "homœopathic" physician, but the *Lancet* contradicts this statement. He does not belong to that pathy. He is a graduate of Kings' College, Aberdeen.

Yellow Fever Items.

—It is stated that Fort Smith, in Arkansas, 460 feet above the level of the sea, is the highest point at which the yellow fever has ever prevailed as an epidemic in this country.

—The Vicksburg *Herald* says:—A gallant ex-Confederate, and successful practitioner of medicine in this city, remarked to us, yesterday, that the present condition of Vicksburg was worse than war. A sad truth.

—The Memphis board of health has adopted a resolution, as follows: "That any one carrying in a public hack, to a place of interment, any yellow fever corpse, shall be fined not less than $10, nor more than $50."

—Dr. Holiday, of New Orleans, says that children born in New Orleans are as liable to take the yellow fever as those born in any other State. No one, native or foreign, is acclimated until he has had an attack of yellow fever.

—A New Orleans correspondent says that a strange feature brought to light by the comparative statistics of convalescent and fatal cases, was the fact that the mortality among the negroes attacked is nearly 60 per cent.; so fatal, indeed, is the disease, that when a full-blooded negro is seized he abandons hope at once.

A young lady on St. Charles street, who was already able to move about the house, and was considered totally out of danger, was severely frightened by a vivid flash of lightning, relapsed into fever within an hour, and died with the black vomit in a few hours.

Items.

—A largely increased edition of the REPORTER will be issued weekly during the fall months.

—The Navy Department has been advised, by Commander Phillips, commanding the Tuscarora, of the death of Surgeon Ed. H. Ware, at Acapulco, on the 13th inst. Orders have been sent for the Tuscarora to return to San Francisco.

—Shameful peculation has been discovered in the finances of the Minnesota State Insane Asylum, by an investigating committee of State Senators. Two of its trustees made a trip to the Centennial Exhibition, at a cost to the State of $3000, and the bills of all the board, for services and mileage, have been equally extravagant.

—Dr. Greensville Dowell, of Galveston, Texas, author of the recent treatise on yellow fever, has been in Memphis for some weeks, having volunteered his services in the epidemic there. He has charge of the Walthall Home, or Infirmary, organized by Mann Walthall, of Mobile.

QUERIES AND REPLIES.

Dr. H. T. B.—We do not know of any material difference in the value of the atomizers you mention, except the one is more complete than the other, as indicated by the price.

Dr. S. C. T., of N. J., desires information in regard to carbolated injections in hydrocele, percentage of carbolic acid, etc.

Dr. W. A. C., of Ga.—There is no specific treatment which has ever proved successful in yellow fever. Each case and each epidemic requires separate study.

Dr. J. W. C. inquires the formula for "Doughtie's Stimulant."

Dr. J. D. McG. and others.—Owing to his many duties, Dr. Goodell has not been able to superintend the publication of his Lectures, and we cannot promise them before November.

J. H. P., of Nebraska.—Thanks for your letter. Its contents will be used and credited.

OBITUARY.

DR. WASHINGTON L. ATLEE,

Of this city, died at his residence on Arch street, on the 6th instant; his malady was cancer of the stomach. Dr. Atlee was born at Lancaster, Pa., on February 22d, 1808, and was, consequently, in his seventy-first year. He was the youngest son of William Pitt Atlee, and grandson of Hon. William Augustus Atlee, one of the early Judges of the Supreme Court of Pennsylvania, his term extending from 1777 to 1793. His maternal grandfather was Major Washington Light, a soldier in the army of the Revolution. At the age of sixteen Dr. Atlee entered the office of his brother, Dr. John L. Atlee, at Lancaster, and subsequently entering Jefferson College, with the third class enrolled at that institution, graduated in 1829. He then returned to Lancaster county, where he practiced his profession and ardently pursued the study of botany and science. In 1849 he removed to this city, and, by invitation, filled the chair of medical chemistry of the Pennsylvania College until 1853, when, his private practice demanding much of his time, he resigned that position. He was an active member of the State and County Medical Societies and the American Medical Association. A brilliant extempore speaker and an able debater, his weight was always cast in favor of a higher medical education and a broad and liberal construction of the rights and duties of medical life. As a practitioner he was most famous for his advocacy of the difficult operation of ovariotomy. Commencing its performance and defending its propriety at a time when hardly another surgeon in the land dared support him, he vindicated its merits by his success in more than three hundred cases.

Dr. Atlee lived to see the practice he sought to establish generally recognized, by many of those, indeed, from whom he encountered the greatest opposition. As a writer, he contributed ably to all the current medical and surgical magazines. The prize essays of the American Medical Association in 1853 included one written by him, and quite recently (1872) he summed up his extended experience, in a volume on ovariotomy. The loss to his profession, which he adorned, and to society, where he was esteemed and admired, is a severe one.

DR. E. M. MARTIN, U. S. N.,

Whose death we announced last week, was the eldest son of Dr. John Martin, who has practiced for some thirty years in this State. In 1874 Dr. E. M. Martin took his degree at the University of Pennsylvania. He then prepared for the naval examination, under Dr. Willard, of Philadelphia, and the same year was commissioned as Assistant Surgeon U. S. N. Immediately he was ordered to the Brooklyn Navy Yard, and with one or two exceptions has been in active service since, serving on a torpedo boat in Brooklyn harbor, on the Lackawanna in the Pacific, and on the ironclad Ajax, at Brandon Va. Owing to protracted mental effort in his professional studies, his health broke down, and he was ordered home some six weeks ago, and on Tuesday, the 20th, he had an attack of apoplexy, from which

he died. The deceased was held in high esteem by his brother officers, by his professional brethren at home, and by his father's patients, among whom he had practiced to some extent. His funeral was largely attended, some thirty physicians being present. His body was attended to the grave by an escort of honor, consisting of Drs. Messersmith, U. S. N.; W. Marshall, U. S. N., and J. Ross Martin, U. S. N.

Bart, Pa., 1878.

DR. BENJAMIN R. ROBSON,

Of New York city, died there last week, in the ninety-third year of his age. Dr. Robson was born in 1785, studied medicine in the office of Dr. Seaman, and at the age of 19 was elected House Surgeon of the New York Hospital. In 1805, he was appointed by Capt. Minot surgeon on board the ship Samson, and on his return to New York commenced practice there as a physician. For sixty years he was in the constant practice of his profession in New York, and became widely known as a most skillful and careful physician; but about 1865 his sight became impaired, and he was compelled to abandon his active duties, his advice, however, being still sought by many of his brother practitioners in difficult cases. Dr. Robson was one of the incorporators of the New York County Medical Society, in 1806, was for many years its treasurer, and at his decease was the oldest member of the society. In 1813, and for many years subsequently, he held the position of Attending Physician to the New York Dispensary. He was a veteran of the war of 1812, having served as Surgeon to the First Regiment, Third Brigade, under Col. Dodge, and was afterward appointed Surgeon on the staff of Gen. Van Rensselaer, Commander-in-Chief of the veterans of that war.

DR. JULIUS AUERBACH

Died the latter part of August. He was one of the most prominent physicians on Long Island, and had practiced his profession there twenty-five years. He was born at Mayence, Germany, in the year 1821. After graduating at Tubingen, he emigrated to this country and completed his course of study in New York and Brooklyn, receiving a practitioner's license from the Queens County Medical Society, in the year 1853. He was a brother of Berthold Auerbach, the noted German novelist, and the latter once dedicated a popular novel to him. Dr. Auerbach's death was indirectly due to an accident. While riding out a few days ago his horse ran away, and the Doctor jumped from his carriage. He escaped with a few slight bruises, but on reaching home he was seized with a fit of coughing, during which his diaphragm was ruptured. Inflammation at once set in, and he died in great agony.

DR. HARWOOD WAKEMAN,

Of New York, was drowned while bathing in the Blue Mountain Lake, in the Adirondacks. Dr. Wakeman was born in New York, about 1849. He was graduated from the Yale College Scientific School, and afterward entered the office of Dr. Lewis A. Sayre, going thence to the Bellevue Medical College, whence he was graduated eight years ago.

DR. HUGHES, OF GRENADA.

A special from Grenada, Miss., says Dr. Hughes is dead. He was the most prominent physician here, and, in fact, of all north Mississippi. His last words were to his attendant physician, Dr. W. P. Beatty, of Mobile: "Please have me buried like a gentleman and physician." Dr. Beatty saw that it was done, laying him out and dressing his body with his own hands, and followed the corpse to its last resting place.

DR. CHARLES M. GRIFFITHS

Died in this city, August 23d, aged seventy-nine years. He was born at Whitehall, in Bucks county, on the 17th of March, 1799, and was the son of Dr. Amos Griffiths. His mother was Elizabeth Weber, daughter of Captain Weber, of the Revolutionary War, who was subsequently an Associate Judge in Montgomery county. Charles M. Griffiths studied medicine, was a diligent student, and was successful in surgery. He retired from practice about fifteen years ago. He was a brother of Dr. Jesse W. Griffiths, who for a long time was in practice in this city.

MR. WILLIAM FISHBOURNE GRIFFITTS

Died August 28th, aged eighty-one years. He was a native of this city, and a son of Dr. Samuel Powell Griffitts, who for many years was a prominent physician. He was for several terms president of the Philadelphia Dispensary, his father having held the same position before him.

MARRIAGES.

GORDON—WADSWORTH—At Davenport, Ia., on August 1st, 1878, by Professor David McDill, D.D., and the Rev. J. W. Coleman, Mr. Joseph C. Gordon, of Washington, D. C., and Miss Anna Sibyl, eldest daughter of Dr. J. Wadsworth, till recently of Cincinnati, Ohio.

LEWITT—SMITH.—August 8th, 1878, in Detroit, Mich., at the residence of M. C. Huyett, 350 Lafayette Avenue, W. B. Lewitt, M.D., and Susie E. Smith, youngest daughter of the late Rev. W. C. Smith.

SHIVERS—PETERSON.—At Haddonfield, N. J. on the 17th inst., by Rev. Joel Rudderow, C. H. Shivers, M.D., and Miss Annie D. Peterson, both of Haddonfield.

WICK—ABRAMS—At the Kent House, Lake View, Chautauqua Lake, N. Y., August 7th, 1878, by Rev. A. C. M'Clelland, Dr. J. Addison Wick and Miss Blanche P. Abrams, both of New Bethlehem, Pa.

DEATHS.

AYERS.—S. J. Ayers, M.D., at Bart, Pa. He was a classmate of E. M. Martin, U.S.N., and a partner of his father, Dr. John Martin.

BULKELEY.—In New York, on Monday morning, August 19th, Julia Neilson, wife of Charles A. Bulkeley and daughter of the late John Neilson, M.D.

CAMPBELL.—Suddenly, on Wednesday morning, August 14th, 1878, Mary Catharine, wife of Dr. N. L. Campbell, of New York.

DAVIS.—In New York, August 23d, 1878, Dr. N. Reynolds Davis, eldest son of Dr. John Davis, of New York city, and late Surgeon of steamship Acapulco, in the fifty-third year of his age.

EDDY.—In Chester, Vt., August 5th, Mary C., wife of Dr. Wm. F. Eddy, forty-four years of age.

FIELD.—In Washington, Vt., July 29th, of heart disease, Dr. E. C. Field, aged 31 years, 8 months and 14 days.

GRIFFITHS.—In Philadelphia, on the 23d instant, Charles M. Griffiths, M.D., in the eighty-second year of his age.

LORD.—At Stamford, Conn., August 23d, in the thirtieth year of his age, John P., son of Dr. John Lord.

ROBSON.—In New York, on August 18th, 1878, Benjamin R. Robson, M.D., in the ninety-third year of his age.

STEARNS.—On Sunday, August 11th, 1878, Daniel E. Stearns, M.D., of New York, aged seventy-seven years.

WAKEMAN.—Harwood Wakeman, M.D., drowned in Blue Mountain Lake, Adirondacks, Thursday, August 15th, in the thirty-first year of his age.

WILLIAMSON.—At New Brunswick, N. J., on Monday, August 12th, 1878, of typhoid fever, Sarah C., wife of Dr. Nicholas Williamson, and eldest daughter of Professor George H. Cook.